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CONFERENCE ABSTRACT

Implementation of the Integrated Care for People with Chronic Conditions (ICPCC) program in practice in Sydney, Australia

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Cathy O'Callaghan[1]

1: University of New South Wales, Australia

Introduction

There is an increasing population with multimorbidities who are at risk of unplanned hospital admissions and emergency department presentations. This population could be better served through a model of coordinated care to manage their health at home.

Practice change

The growing population at risk of potentially preventable hospitalization (PPH) and emergency department presentations could be reduced through coordinated care that uses a patient identification algorithm of disadvantage or referral of a patient through a health professional.

Aim and theory of change

This project examines the implementation of an Integrated Care for People with Chronic Conditions (ICPCC) Program at South Eastern Sydney in practice using Normalization Process Theory (NPT) to understand the factors that inhibit or promote it (May 2015). Qualitative methods were used to understand how the Program has been implemented at the State, District, program, clinician and consumer levels; and the characteristics of patients included to the program through various means.

Targeted population and stakeholders

Data include a focus group with ICPCC program staff and 15 semi-structured interviews with NSW Health, Care Coordinators, Integrated Care Unit managers as well as and health professionals who refer patients to the program.

Timeline

2019 to 2020.

Highlights

All levels of participants interviewed stated the importance of achieving the systemic goals of keeping people out of hospital together with enhancing patient centred outcomes and goals. The ICPCC program does not just focus on reducing morbidities but on assisting people to overcome barriers to reach their overall health goals.

The program implementers viewed the risk algorithm as beneficial, but health professionals who refer patients to the program also result in positive outcomes through stating their specific needs and linking them to services.

Sustainability

The importance of linking and having strong relationships with local community health services assists long term commitment and integration of services.

Transferability

Evidence highlights the importance of understanding the context of where the intervention is being implemented.

Conclusions

The ICPCC program plays an important role is assisting patients with their physical and social needs who are at the early stage of their disease trajectory and who have to capacity to self-manage.

Discussions

Program implementers and managers were conscious of the need to reduce duplication of health services and improve service efficiency in a cost cutting environment. Patients were assessed as eligible for treatment in the context of whether a multi-disciplinary team were already involved and what contribution the ICPCC program could provide.

Lessons

Chronic care algorithms have proved useful in predicting risk and are used elsewhere in Australia. However, such algorithms do not identify all suitable patients especially those in the community with rising risk who have not been admitted to hospital. The need to integrate hospital and community data in identifying patients has therefore been highlighted.